BURBANK
Audiology Center

Patient Registration Form

Patient Name _____ Date _____

Parents Name (if patient is under 18) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Phone Number Home _____ Cell _____

Referring Physician _____

Primary Care Physician (if different from referring MD) _____

Send report to

☐ Referring Physician ☐ Primary Care Physician ☐ Both ☐ Self Email _____

Physician Phone _____ Physician Fax _____

Primary Insurance _____

Please give insurance cards to office staff to make copies.

Primary Insurance Holder (if different from patient) _____

Policy Holder SSN _____ Policy Holder Date of Birth _____

In Case of Emergency Contact _____ Relationship _____

Phone Home _____ Cell _____ Work _____

I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on my claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to which I am entitled to Burbank Audiology Center. I understand that I am responsible for any copayments at the time of the visit.

Signed _____

Patient/Legal Guardian

2211 W. Magnolia Blvd., Suite 260, Burbank, CA 91506

Ph: 818-859-7730 | Fx: 818-859-7732